



Office of Early Childhood & Out-of-School Learning

Training Equivalency Verification Form

A COPY OF THIS FORM SHOULD BE MAINTAINED IN THE INDIVIDUAL'S TRAINING FILE

Date: _____

Name of Staff person (please print): _____ Position: _____

Name of Director/Owner: _____

Phone Number: () - _____ Fax Number: () - _____

Email Address (please print clearly): _____

Name of Facility/Home: _____

License/Registration/PES Number: _____

REQUESTED HEALTH AND SAFETY ORIENTATION TOPIC AREA:

All the following documentation must be attached to determine whether the training is equivalent:

- Name of training
- Training certificate/transcript
- Training content/subject and objectives
- Date of the training
- Name and credentials of trainer/training organization
- Type of training
- Number of clock hours of training in the required topic area

CCR&R Agency- _____

CCR&R Staff- _____ Date _____

- Approved as equivalent
- Not approved
- Request Early Learning Indiana Review